ViaCord ID:_____

Medical Referral Form

Thalassemia

THE SIBLING CONNECTION
ViaCord's Newborn Stem Cell Donor Program

Patient Name (PRINT) | Patient Gender: M / F | Patient Date of Birth | Patient Weight in Kg.

Mother's Name (PRINT) | Mother's Phone # | Mother's Email | Due Date

☐ **Pregnancy is a FULL sibling** (Please check box to confirm)

MEDICAL INFORMATION

Genotype

☐ β major ☐ E - β + ☐ E - βº ☐ α - major ☐ Hb H ☐ other than intermediate

Surgical History

Splenectomy: ☐ No ☐ Yes, age: _____

Infections History

HCV: ☐ No ☐ Yes ☐ Not Tested

Transfusion History

Chronic transfusion: ☐ No ☐ Yes, every _____ weeks

RBC alloantibodies: ☐ None ☐ Yes (circle): Kell E e C c other(s)_____

Approx. Total RBC transfusions: ☐ None ☐ 1-10 ☐ >10 ☐ >50

Medications

Any hormone replacement: ☐ No ☐ Yes

HCV treatment: ☐ No ☐ Yes

Iron chelation therapy: ☐ No ☐ Yes, current dose is: _____ every: _____

Other medication(s): _____

Complications Related to Thal or Hemochromatosis

Hepatomegaly: ☐ No ☐ Yes (circle): <2cm >2cm

Portal fibrosis: ☐ No ☐ Yes, age diagnosed: _____ grade: _____

Cirrhosis: ☐ No ☐ Yes, age diagnosed: _____ grade: _____

Cardiac dysfunction: ☐ None ☐ Yes, age diagnosed: _____ describe: _____

Gonadal failure: ☐ None ☐ Yes, age diagnosed: _____ describe: _____

Diabetes mellitus: ☐ None ☐ Yes, age diagnosed: _____ describe: _____

Summary/Comments (Please add extra pages if necessary)

_____

TREATING PHYSICIAN INFORMATION

Physician Name | Specialty

Phone | Email (Required)

Fax | Hospital

Physician Office Address | City | State | Zip Code

Other Contact Name (RN/NP) | Other Contact Phone

(Please check box to agree)

☐ **It is my medical judgment that this patient has a condition that may be treated with a hematopoietic stem cell transplant using sibling cord blood stem cells**

Reporting Provider Name (PRINT) | Signature | Date

Please return completed form to ViaCord.
Fax: 781-240-8427 or Email: SiblingConnection@ViaCord.com